Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 3 - Provider Customer Services

Table of Contents

(Rev. 3, 12-09-03)

10 - Introduction

(Rev. 1, 10-01-03)

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing correspondence. Normally, the term "contractor" is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, this will be specified.

20 - Provider Services

(Rev. 3, 12-09-03)

A2-2959, B2-5105

The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve the Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. Every member of the customer service team should be committed to providing the highest level of service to our partner, the Medicare provider. This commitment should be reflected in the manner in which each provider inquiry is handled. The following guidelines are designed to help ensure that the CMS high standards of service are met.

20.1 - Written Inquiries

(Rev. 3, 12-09-03)

A2-2959, B2-5105.A

20.1.1 - Requirements for Handling Written Inquiries

(Rev. 3, 12-09-03)

A2-2959.A, B2-5105.A.1

- Date Stamping: Contractors must stamp all written inquiries with the date of receipt in the corporate mailroom and control them until final answers are sent.
- Timeliness: Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

If contractors are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45 day period starts on the same day for both responses).

Contractors must ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is the most efficient for the conditions. If contractors respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor will have the flexibility to respond to provider written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: provider's name and address, telephone number, provider number, date of contact, internal inquiry control number, subject, summary of discussion,

status action required (if any) and the name of the customer service representative who handled the inquiry. Upon request, send the provider a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. Use the correspondence, which includes the requestor's telephone number or use a requestor's telephone number from internal records if more appropriate for telephone responses. If the requestor cannot be reached by phone, contractors do not leave a message for the provider to return the call. A written response should be developed within 45 calendar days from the incoming inquiry if the matter cannot be resolved by phone.

- Typewritten Responses: All responses must be typewritten using a font size of 12 and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.
- Contact Information: Include a contact's name and telephone number in the response.
- Appeal Requests: Forward all valid appeals requests to the appeals unit for handling.
- CMS Alpha Representation: Include the official CMS alpha representation on all responses.
- Reproduction: Keep responses in a format from which reproduction is possible.

20.1.2 - Requirements for Responding to Written Inquiries

(Rev. 3, 12-09-03)

A2-2959.A.2, B2-5105.A.2, B2-5105.A.3

Contractors must establish and implement a written plan to strengthen the quality of written responses. The plan should include an internal review process and activities to ensure that the quality of communications is continuously improving. These responses should be reviewed and appraised based on the following requirements for written inquiries:

- **Accuracy -** Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the writer's understanding of the issues that prompted the inquiry.
- **Responsiveness** - The response addresses the writer's major concerns and states an appropriate action to be taken.
- **Clarity** - Letters have good grammatical construction, sentences are of varying lengths (as a general rule, keep the average length of sentences to no more than 12-15 words), and paragraphs generally contain no more than five sentences. All written inquiries are to be processed using a font size of 12 points and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.

- **Timeliness** - Substantive action is taken and an interim or a final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for the delay. All responses, including computer-generated letters and form letters, should be user-friendly and understandable by the reader.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45-day period starts on the same day for both responses).

Contractor personnel must ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined or separate, depending on which procedure is most efficient for a contractor's conditions. If the contractor responds separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor must have the flexibility to respond to provider written inquiries by phone within 45 calendar days. They should develop a report of contact for tracking purposes. It should include:

- Provider's name and address,
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;
- Subject;
- Summary of discussion;
- Status, action required (if any); and
- The name of the customer service representative who handled the inquiry.

Upon request, the contractor sends the provider a copy of the report of contact that results from the telephone response. The contractor retains the report of contact in the same manner and time frame as it does for written responses.

The contractor uses its discretion to identify which written inquiries (e.g., provider correspondence that represent simple questions) it can answer by phone. It uses the correspondence, which includes the requestor's telephone number or it obtains a requestor's telephone number from internal records if it can more appropriately respond to the inquiry by telephone. If the contractor cannot reach the requester by phone, it does not leave a message for the requester to return the call. It prepares a written response within 45 calendar days from the incoming inquiry if it cannot resolve the matter by phone.

Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Contractors must appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

A - Written Inquiries Files

- Some contractors house files at a remote location during the year due to costs and space constraints. Those contractors must notify CMS within six weeks of the final BPR date of the exact address/location of their off site written inquiries. This information should be sent electronically to the servicing RO Beneficiary Branch Chief. In the event an onsite CPE review is conducted, contractors are required to allow CMS access to all written inquiries stored off site within 1 day of notification to the contractor.
- All written inquiries, whether maintained on site or off site, must be clearly identified and filed in a manner that will allow easy selection for the CPE review. Identification data must be kept that will allow electronic production of a sequential listing of the universe of written inquiries.

Effective FY 2003, all contractors will be expected to:

- Involve clinicians as needed in developing responses to coverage/coding inquiries from providers.
- Use clinicians in scoring the accuracy of responses to coverage/coding inquiries in their quality appraisal program

B - E-mail Inquiries

Any E-mail inquiry received can be responded to by E-mail. Since E-mail represents official correspondence with the public, it is paramount that contractors use sound E-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by E-mail. Contractors must ensure that all E-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.).

20.2 - Telephone Inquiries

(Rev. 3, 12-09-03)

A2-2959.C, B2-5105.C

The guidelines established below apply to all calls to telephone numbers the contractor established as general provider inquiry numbers. The standards do not apply to those inquiries handled by other units within the contractor (i.e. appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) must be separate from beneficiary inquiry numbers. Providers should not use numbers established for inquiries from beneficiaries. (For MSP Situations, see Medicare Secondary Payer (MSP) Manual, Chapter 4, §§10, 80, 110; and Chapter 5, §10.)

A - Availability of Telephone Service

Contractors must:

1. Hours of Operation: Make live telephone service available to callers continuously during normal business hours--including break and lunch periods. The minimal "normal business hours" for live telephone services are 9:00 a.m. until 3:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a request for a waiver related to standard hours of operation.
2. IVR Hours of Operation: To the extent possible, the IVR shall be available to providers from 6:00 a.m. through 10:00 p.m. in their local prevailing time, Monday through Friday, and from 6:00 a.m. until 6:00 p.m. on weekends. Allowances may be made for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. Contractors should identify what services can be provided to providers during the processing system unavailable time.

   NOTE: Interactive Voice Response Units (IVR) should be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVRs
3. Delay Message: Although the provider should have the ability to speak with a CSR during operating hours, if callers encounter a temporary delay before a CSR is available, a recorded message will inform them of the delay. The message will also request that the provider have certain information readily available before speaking with the agent. During peak volume periods, the message shall indicate the preferred time to call.
4. At the beginning of each fiscal year, contractors will send CMS their list of call center holiday closures for the entire fiscal year. This information should be sent to: ServiceReports@cms.hhs.gov. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work (e.g., provide CSR training.
5. Call Center Staffing: Staffing should be based on the pattern of incoming calls per hour and day of the week ensuring that adequate coverage of incoming calls throughout the workday is maintained in accordance with call center standards. Telephone service must not be interrupted in order to conduct CSR training.
6. CSR Identification to Callers: CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will by optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for

remote monitoring purposes. The CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

7. Performance Improvements: As needed, develop a corrective action plan to resolve deficient performance by staff in the call center, and maintain results on file for CMS review.

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of IVR. The contractor should strive to use the IVRs based upon lessons learned and best practices throughout CMS and its partners. All contractors are required to utilize an IVR that meets the following guidelines:

- Busy Signals: Call center customer premise equipment should not be configured/programmed to return "soft busies." Contractor call centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor should optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.
- IVR Content: The IVR should offer at least the following information:
    1. Contractor hours of operations for inbound Medicare provider CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold.
    2. General Medicare program information.
    3. Specific information regarding claims in process and claims completed.
    4. A statement if additional evidence is needed to have a claim processed.
    5. Information about appeal rights and actions required of a provider to exercise these rights.
- IVR Call Flow: Call centers must submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are performing through the IVR. Contractors must also indicate how they are authenticating the call when claim specific information is involved. The contractors can deliver this document in Visio, Paintbrush, Word, or PowerPoint. A copy should be sent to both the contractor's regional office (RO) and the central office (CO) at ServiceReports@cms.hhs.gov. If the contractor changes the IVR script or call flow, they must submit a revised document to these parties within 2 WEEKS OF IMPLEMENTING THE CHANGES.
- IVR Operating Guide: The contractors must have a readily understood IVR operating guide to distribute to providers upon request.

B - Toll-Free Telephone Service Costs

The CMS will use the General Service Administration's Federal Telephone Service (FTS) 2001 contract for all inbound toll-free service. Any new toll-free numbers and the associated network circuits used to carry these calls will be acquired via the FTS 2001 network. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS and should not be considered by contractors in their budget requests. However, Medicare contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors must maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and provide this information upon request by RO or CO.

Contractors must print on their notices and Web sites any toll-free Medicare provider customer service number that the CMS provides and pays for. Contractors display this toll-free number prominently so the reader will know whom to contact regarding the notice.

C - Customer Service Representative (CSR) Standard Desktop

The CMS is transitioning to the Medicare Customer Service Center Next Generation Desktop (MCSC NGD) FOR Medicare contractors. Listed below are the minimum personal computer (PC) requirements for the MCSC NGD for CSRs. Contractors are reminded that they are required to capitalize and depreciate equipment valued at over $500.

Minimum Requirements for an NGD Personal Computer

Processor:	Pentium II 233MHz or comparable AMD or Cyrix
Disk Space:	10MB available
Memory:	64MB (more recommended for running multiple applications simultaneously with the NGD)
Operating System:	One of the following 4 options: • Windows 98 SE • Windows ME • Windows NT Workstation 4.0 with Service Pak 6a • Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	15" (17" or larger is preferable)
Pointing Device:	Mouse
Network Interface:	Network Interface Card compatible with the call center LAN which will ultimately allow workstation access to AGNS

Organizations that will be procuring new PCs because they currently do not have PCs or because they need to upgrade for reasons other than the new NGD application, may want to procure more current PC technology. While the minimum PC requirements should be used to evaluate if existing desktop systems are adequate, the following suggested configuration provides guidance when new hardware is purchased:

Guidance for New PCs If and Only If Existing PCs Do Not Meet Minimum Requirements

Processor:	1.0 GHz Processor (Pentium, Celeron, or AMD)
Disk Space:	20 GB Hard drive
Memory:	256 MB (minimum)
Operating System:	Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	17" or larger
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN which will ultimately allow workstation access to AGNS

This hardware should provide good performance running the combination of applications expected of typical NGD users. These applications include, but are not limited to:

- Next Generation Desktop (using Internet Explorer)
- Microsoft Word
- Microsoft Outlook (or other e-mail/calendar package)
- Adobe Acrobat Reader, Folio, or other document viewing software

Personal Computer Software:

- Web browser (Internet Explorer 5.5 Service Pack 2)
- Microsoft Word '97 (or higher version) – required only for generation of correspondence.

Contractors will be required to implement the new desktop application as it is rolled out. The CMS will provide additional information on rollout dates and associated activities through normal operating channels and contractors will be given a minimum of 90 days advance notice of desktop implementation. Contractors are responsible for providing the necessary support to implement the desktop. These support activities will vary in scope from one contractor to another based on the various technologies and operational practices employed at each site. Examples of support activities may include additional systems testing, connecting to contractor specific applications, pre and post deployment activities, training needs and other issues. Contractors should include implementation and all associated costs for the CSR desktop in the Provider Telephone Inquiries Activity Code 33001.

D - Inquiry Staff Qualifications

Contractors train CSRs to respond to provider questions, whether of a substantive nature, a procedural nature, or both. The CSRs who answer telephone calls must be qualified to answer general questions about initial claims determinations, operation of the Medicare program, and appeal rights and procedures. To ensure that these services are provided, CSRs should have the following qualifications:

- Good keyboard computer skills;
- Good telephone communications skills;
- Sensitivity for special concerns of the Medicare providers;
- Flexibility to handle different situations that may arise;
- Knowledge of Medicare claims processing and review procedures;
- Prior experience in positions where the above skills are used, e.g., claims representative or telephone operator, is desired, but not required;
- Contractors will provide training for all new CSR hires and training updates as necessary for existing personnel. This training should enable the CSRs to answer the full range of customer service inquiries. The training at a minimum should include technical instructions on Medicare eligibility, coverage benefits, claims processing, Medicare systems and administration, customer service skills and telephone techniques, and the use of a computer terminal. Contractors must have a training evaluation process in place to certify that the trainee is ready to independently handle questions;
- During FY 2003, CMS will be developing testing and issuing standardized training processes and materials for provider telephone CSRs. Upon receipt of these materials, contractors are required to implement these standardized CSR training materials, including job aids for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures;

- Send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors should be prepared to send at least one customer service/provider education representative to these training sessions to represent areas of provider education/customer service, payment, claims processing, billing, and medical review. Contractors should expect training sessions to run from 2-4 days. This representative will be responsible for training additional contractor customer service staff. These staff members should also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives; and

Call Center User Group (CCUG) Call: Call centers are required to participate in the monthly CCUG calls. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern time. The CCUG sessions provide a forum for CMS to discuss new and ongoing projects related to telephone customer service, for contractors to surface issues for CMS resolution, and call centers to share best practices in telephone customer service delivery. The call center manager or a designated representative must participate ate a minimum.

E - Customer Service Assessments and Management System (CSAMS)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display Call Center Telephone Performance data. Contractors use the following guidelines for the appropriate CSAMS reporting:

- Monthly Reports: Each call center site must enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To correct or change data after the10th of the month, users must inform central office via CSAMS at csams@cms.hhs.gov. All specified information must be captured and reported to CMS on a monthly basis via the CSAMS. This information may be captured manually, if necessary, to calculate each required field.
- Call Center Definition for CSAMS: All contractors must ensure that monthly CSAMS data are being reported by individual call center and that the data are not being consolidated. The CMS wants telephone data grouped at the lowest level possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, MCSC, or some breakout/consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, State, etc.
- The CSRs Sign-in Policy: Establish and follow a standard CSR sign-in policy in order for CMS to ensure data collected for telephone performance measurement is consistent from contractor to contractor. This policy will include the following:
    1. The CSRs available to answer telephone inquiries will sign-in to the telephone system to begin data collection.
    2. The CSRs should sign-off the telephone system for breaks, lunches, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR work-state or category that accumulates this non-telephone inquiry performance data so that it can be separated and not be utilized in lieu of CSRs signing off the system.)

3. The CSRs should sign-off the telephone system at the end of their workday.
4. Call Handling Reporting Requirements for CSAMS:

- Contractors must track and report "Total Sign-in Time" (TSIT). Total sign-in time is the amount of time that CSRs were available to answer telephone inquiries. This time includes that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
- Contractors must track and report "Available Time." Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the After Call Work [ACW]state).
- Contractors must track and report "Number of Workdays." Number of workdays is the number of calendar days for the month that the call center is open and processing telephone inquiries. For reporting purposes, a call center is considered open for the entire day even though the call center may have been closed or not able to process telephone inquiries for a portion of the day.
- Contractors must track "Call Acknowledgement Rate." Call acknowledgement rate is the time it takes a system to acknowledge a call before an agent, IVR, or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported but must be substantiated when requested.
- Contractors must track and report "Service Level Indicator." For callers choosing to talk with a CSR, calls shall be answered within a specified time of their delivery to the queuing system. This rate should be reported to CMS monthly.
- Contractors must track and report "Initial Call Resolution." A call is considered resolved during the initial contact if it does not require a return call by the CSR.
- Contractors must track and report "Number of Attempts." Report the monthly total FTS toll-free calls offered to the provider call center during the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-CMS calls. This should be taken from reports produced by FTS Toll-free service provider. The current provider is WorldCom and the reports are available at their Web site, http://customercenter.worldcom.com.
- Contractors must track and report "Call Abandonment Rate." Call abandonment rate is the percentage of provider calls that abandon their call from the ACD queue up to and including 60 seconds.
- Contractors must track and report "Average Speed of Answer." Average speed of answer is the amount of time that all calls waited in queue before being connected to a CSR. This time begins when the caller enters the queue (it includes ringing, delay recorder(s), and music.

- Contractors must track and report "Average Talk Time." Average talk time is any time the caller is placed on hold by the CSR.
- Contractors must track and report "Productivity." Productivity is the average number of calls handled per CSR.
- Contractors must track and report "After Call Work." After call work (ACW) is the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.
- Contractors must track and report "Call back Report." Call back is the number of calls not resolved at first contact. Those calls should be reported as follows:
- Callbacks required: This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.
- Callbacks closed within 5 workdays: This number is based on calls received for the calendar month and represents the number of inquiries closed within 5 workdays even if a callback is closed within the first 5 workdays of the following month. For call centers that have transitioned to the Next generation desktop (NGD), the collection of this data point will be automated and will be based on 7 calendar days rather than 5 workdays.
- IVR Handle Rate: Contractors should report the IVR handle rate. This is the number of calls delivered to the IVR where providers received the information they required from the automated system.

F - Quality Call Monitoring Process

Contractors must monitor, measure, and report the quality of service continuously by employing CMS' quality call monitoring (QCM) process. Copies of the official scorecard and chart may be obtained at the telephone customer service Web site at http://www.cms.hhs.gov/callcenters/qcm.asp. Contractors use only the official version of the scorecard posted at the Web site.

1. QCM Sampling Method: Monitor CSRs throughout the month using a sampling routine. The sampling routine must ensure that CSRs are monitored at the beginning, middle, and end of the month (ensuring that assessments are distributed throughout the week and during morning and afternoon hours). Monitor the calls in any combination of the following ways: live remote, live side-by-side (shadow), or taped. For taped calls CMS requires contractors to maintain such tapes for an on-going 90-days period during the year. All tapes must be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Where possible, rotate auditors regularly among the CSRs.
2. Calibration Calls: Participate in national and regional calibration sessions in organized by CMS. Calibration is a process to help maintain fairness, objectivity, and consistency in scoring calls by staff within one or more call centers or throughout CMS. Instructions on how to conduct calibration are posted at the telephone customer service website. National sessions are

held on the first Wednesday of February, May, August, and November at 1:30 Eastern time. Contractor call centers with more than one quality assurance analyst should conduct regular calibration sessions.

3. Scorecard: Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.
4. Feedback to CSR: Complete the scorecard in its entirety and give feedback to the CSR in a timely fashion, coaching and assisting the CSR to improve in areas detected during monitoring. Feedback on monitored calls shall be given to within two business days for live monitored calls and within seven business days for recorded calls.

G - QCM Reporting Requirements for CSAMS

Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls without assistance of a "mentor." Scores for these trainees may be excluded from CSAMS reporting for a period up to one month following the end of formal classroom training.

- QCM-Number of CSRs available for monitoring: Contractors must track and report the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time. This number is obtained from the QCM Database.
- QCM-Number of completed scorecards: Contractors must track and report the number of completed scorecards for the month. This number is obtained from the QCM Database.
- QCM-Customer Skills Assessment: Contractors must track and report the percent of calls monitored that scored greater than or equal to Meets expectations. This number is obtained from the QCM Database.
- QCM-Knowledge Skills Assessment: Contractors must track and report the percent of calls monitored that scored greater than or equal to Meets Expectations. This number is obtained form the QCM Database.
- QCM-Privacy Act: Contractors must track and report the percentage of calls that scored as pass. This number is obtained from the QCM Database.

H - Calls Regarding Claims

When a telephone representative receives an inquiry from a provider about a claim, first, verify the provider's name, identification number. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the caller.

I - Calls Regarding Fraud and Abuse

If a caller indicates an item or service was not received, or that a beneficiary or provider is involved in some potential fraudulent activity, screen the complaint for billing errors or abuse before sending it to the Benefit Integrity Unit. After screening the claim, if

the CSR suspects abuse, the Medical Review Unit would handle the complaint. If the CSR suspects fraud, the complaint is forwarded to the Benefit Integrity Unit and the CSR informs the caller that the Benefit Integrity Unit will contact him/her about the complaint. The CSR asks the caller to provide the Benefit Integrity Unit with any documentation he or she may have that substantiates the allegation. The CSR assures caller that the matter will be investigated.

J - Equipment Requirements

To ensure that inquiries receive accurate and timely handling, contractors provide the following equipment:

- Online access to a computer terminal for each telephone representative responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;
- An outgoing line for callbacks; and
- A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

Any contractor call center upgrades or initiatives for purchases or developmental costs of hardware, software, or other telecommunications technology that equal or exceed $10,000 must first be approved by CMS. Contractors shall submit all such requests to the servicing RO for review.

The RO shall forward all recommendations for approval to CO for a final decision

K - Publicizing Provider Toll-Free Lines

Effective with the publication of these instructions, contractors will not be responsible for publishing their provider inbound 800 numbers in local telephone directories. The CMS will publish provider inbound 800 numbers in the appropriate directories. No other listings are to be published by the contractor.

However, contractors must publicize the toll-free service to the providers they serve in other normal business ways. An announcement about the availability of the service should be prominently displayed and maintained on contractor's Medicare Web site. Toll-free numbers should also be displayed on all provider education materials. Finally, the toll-free numbers should be publicized at all scheduled provider conferences, meetings and workshops.

20.3 - Processes for Line Changes, Troubleshooting, and Disaster Recovery

(Rev. 3, 12-09-03)

A2-2959.D, B2-5105.D

A - Ordering More Lines, Changing Configurations, or Disconnecting Lines

The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or Tis, office moves, routing changes), must be processed through SAIC, the Provider Telecommunications Technical Support Contractor.

The CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of CSAMS data and traffic reports.

In requesting changes to the phone environment, the contractor should follow the process outlined below:

Contractors will provide an analysis of their current telephone environment including a detailed traffic report specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information should be gathered at the contractor site through the contractor's switch reporting as well as through WorldCom Customer Center (previously Interact).

- Based on technical merit and availability of funds, CO will review the recommendation and make a determination.

In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

B - Troubleshooting

To ensure that provider toll-free service is available and clear, CMM established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard, incident response and resolution system for Medicare contractors who are troubleshooting problems and processing required changes for the toll-free provider lines.

The CMM has assembled a multi-functional team, consisting of both MCI telecommunications support and CMM Technical Support Contractor (TSC) personnel; to quickly and effectively resolve reported problems. To report and monitor a problem, contractors follow these steps.

Step 1

Isolate the problem and determine whether it is caused by internal customer premise equipment or the toll-free network service:

Internal Problem - The contractor's local telecommunications personnel should resolve, but report per steps below.

Toll-Free Network Service Problem - Contractor reports the problem to MCI by calling 1-888-387-7821.

Step 2

Involve CMM's Technical Support Contractor (TSC), if needed, to answer technical questions or to facilitate discussions with the GSA FTS provider service.

Step 3

File an incident report with the TSC for major interruptions of service. The TSC will notify CMM staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service.

Step 4

Utilize WorldCom Customer Service to review documentation, track trouble tickets status, or close a trouble ticket online.

Step 5

File a monthly report with CMM about interruption of service - including both those of MCI and in-house origins and send a copy to the contractor's CMS Regional Office.

C - Disaster Recovery

When a call center is faced with a situation that results in a major disruption of service, the call center must take the necessary action to ensure that callers are made aware of the situation.

This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center must contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Once the problem is resolved, the call center must also contact the BNS to de-activate the FTS 2001 network disaster messages.

For provider call centers, contractors contact the BNS should only for the disaster situations. It will manage only these types of requests. The CMS designed the single point of contact to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS contacts and updates the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers should follow their normal procedures.

30 – Disclosure Desk Reference for Call Centers – Provider Portion

(Rev. 3, 12-09-03)

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
22. A Provider/Physician Part A or B	Provider/physician inquires about claims information on a pre-claim basis		No claims information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
23. A Provider/Physician Part A or B	Provider/physician inquires about claims information on a post-claim basis.	Validate the provider/physician's name and identification number. Verify the beneficiary's: ● Date of Service ● Last name and first initial ● HIC number Items must match exactly.	**Assigned Claims** Participating and Non-Participating: Discuss any information on that provider/physician's claim or any other related claim from that provider/physician for that beneficiary. **Non-Assigned Claims** Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

			denied. General Note: You may speak with the provider/physician about his/her own claims. You may also disclose information about another provider/physician, as long as both providers/ physicians have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the provider/physician that receives the information.	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
24. A Provider/physician Part A	Provider/physician inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the provider/physician's name and identification number. Verify the beneficiary's: ● Last name & first initial ● Date of birth ● HIC number ● Gender Items must match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Date of death – Lifetime reserve days remaining – Lifetime psychiatric days remaining (if the requesting caller has a psychiatric identification number) – Cross reference HICN – Current and prior A and B entitlements – Spell of illness: hospital full and coinsurance days remaining, SNF full days and coinsurance days remaining, Part A cash deductible remaining to be met,	100-1, Ch. 6, §40 & 60.1

			date of earliest billing action for indicated spell of illness – Blood deductible (combined Part A and B) remaining to be met for applicable year entered by provider – Part B trailer year (applicable year based on date entered by provider) – Part B cash deductible – Physical/speech and occupational therapy amount – Hospice data (applicable periods based on the date entered by the provider and the next most recent period) – ESRD indicator – Rep payee indicator – MSP indicator – HMO information: identification code, option code, start & termination date	

			– Pap smear screening: risk indicator, professional and technical date – Mammography screening: risk indicator, professional and technical date – Colorectal screening: procedure code, professional and technical date – Pelvic screening: risk indicator and professional date – Pneumococcal pneumonia vaccine (PPV) date – Influenza virus vaccine date – Hepatitis B vaccine date – Home health start and end dates and servicing agency's name.	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
25. A Provider/Physician Part B	Provider inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the provider's name and provider number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items must match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy amount	100-1, Ch. 6, §40 & 60.1

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
26. Supplier DMERC	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
27. Supplier DMERC	Supplier inquires about claims information on a post-claim basis.	Validate the supplier's name and NSC identification number Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items must match exactly.	**Assigned Claims** Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary. **Non-Assigned Claims** Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

			General Note: You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
28. Supplier DMERC	Supplier inquires about a Certificate of Medical Necessity (CMN) NO claim has been submitted.		You may not release answers to the question sets on the CMN on file without the beneficiary's authorization.	
29. Supplier DMERC	Supplier inquires about a Certificate of Medical Necessity (CMN) Supplier receives a claim denial due to the CMN. This information may only be used in order to submit an accurate claim.	Validate the supplier's name and NSC identification number. Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number ● HCPCs code or name of item Items must match exactly.	You may confirm whether or not the answers to the question sets on the CMN on file matches what the supplier has in his/her records.	
30. Supplier	Supplier inquires about	Validate the supplier's	Release the following	100-1, Ch. 6, §40 & 60.1

DMERC	beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	name and NSC identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items must match exactly.	eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency 's name. -- Physical/speech and occupational therapy limit	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
31. Ambulance Supplier	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
32. Ambulance Supplier	Supplier inquires about claims information on a post-claim basis.	Validate the supplier's name and identification number Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items must match exactly.	**Assigned Claims** Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary. **Non-Assigned Claims** Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

			General Note: You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
33. Ambulance Supplier	Supplier inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the supplier's name and identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items must match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy limit	100-1, Ch. 6, §40 & 60.1

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
34. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	
35. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a post-claim basis.	Validate the employing provider/physician/ supplier's name and identification number. Verify beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items must match exactly.	You may speak with the billing service/clearinghouse about the employing provider/physician/ supplier's claims.	
36. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about beneficiary	Validate the employing provider/physician/supplier's name and	Release the following eligibility information on a pre-claim or post-	

	eligibility information**,** which would be available via EDI. This information may only be used in order to submit an accurate claim.	identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items must match exactly.	claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy limit	

General Notes and Definitions

ASSIGNMENT	When a provider agrees to accept Medicare approved charges as payment in full and the beneficiary agrees to have Medicare's share of the cost of service paid directly to the provider.
BILLING SERVICE	Collects provider/physician/supplier claim information and bills the appropriate insurance companies, including Medicare. It may provide claims billing service only, or provide full financial accounting
CLEARINGHOUSE	Transfers or moves EDI transactions for a provider/physician/supplier and translates the data into the format required by a health care trading partner, such as a payer. A clearinghouse accepts multiple types of claims and generally other EDI transactions and sends them to various payers, including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers/physicians/suppliers. They perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider/physician/supplier. Clearinghouses frequently reformat data for various payers and manage acknowledgements and remittance advice. Clearinghouses ordinarily submit initial claims and may qualify as a billing service.
DATE OF SERVICE	The date on which the beneficiary received health services from a provider, physician or supplier.
	and/or other services. Billing services may view beneficiary or provider data to perform their obligations to the provider/physician/supplier, and if the provider/physician/supplier designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider/physician/supplier's behalf.
DISCLOSURE	Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains must authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.

NONASSIGNMENT When a provider has not agreed to accept Medicare approved charges as payment in full and the claim potentially is payable directly to the Medicare beneficiary.

NONPARTICIPATING PHYSICIAN A physician who has not signed a participation agreement and is not obligated to accept assignment on Medicare claims; may accept assignment of Medicare claims on a case-by-case basis.

PARTICIPATING PHYSICIAN A physician who has signed a participation agreement to accept assignment on all claims submitted to Medicare.

PHYSICIAN Doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.2), doctor of podiatric medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.3), or doctor of optometry (within the limitations of Pub. 100-1, Chapter 5, subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

NOTE: The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

POST-CLAIM After a provider, physician or supplier services a beneficiary and a claim has been submitted for that beneficiary.

PRE-CLAIM Before the provider, physician or supplier services a beneficiary and before a claim has been submitted for that beneficiary.

PROVIDER Section 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as:

(1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case

of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) A community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each must meet in order for their services to be considered covered are described in the following sections.

RELATIONSHIP When a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.

REPRESENTATIVE PAYEE This is a person or organization appointed by the Social Security Administration when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.

SUPPLIER An entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners.

The following suppliers must meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers.

A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

GENERAL NOTES:

Blended call centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls regarding eligibility inquiries and claims issues on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they should refer the contact to the appropriate provider inquiry number.

An individual who makes a request by telephone must verify his/her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If you do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees must follow the MCSC rules governing disclosure, which require CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, refer the contact to the Managed Care organization. You may not release any Managed Care claims information. **NOTE:** Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care Organizations, unless the representative payee has that authority under State law.

The written authorization must:

- Include the beneficiary's name, and HIC;
- Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;
- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed;
- A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as "at the request of the individual");
- Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary's enrollment in the health plan);
- Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative's authority to act for the individual must also be provided; and
- A statement describing the individual's right to revoke the authorization along with a description of the process to revoke the authorization;
- A statement describing the inability to condition treatment, payment, enrollment or eligibility for benefits on whether or not the beneficiary signs the authorization;
- A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.

For non-English speaking beneficiaries, you must obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR should ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

If the ARU or IVR system is not currently programmed to obtain all of the disclosure elements, and it is necessary for the CSR to answer the call, the CSR should obtain the required data elements before disclosing any identifiable information.

These instructions do not change any requirements for contractors regarding the use of ARU/IVR systems. You are not authorized to reprogram the ARU or IVR at this time.

For situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official

40 - Provider Services

(Rev. 1, 10-01-03)

A2-2959, B2-5105

The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve the Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. Every member of the customer service team should be committed to providing the highest level of service to our partner, the Medicare provider. This commitment should be reflected in the manner in which each provider inquiry is handled. The following guidelines are designed to help ensure that the CMS high standards of service are met.

40.1 - Written Inquiries

(Rev. 1, 10-01-03)

A2-2959, B2-5105.A

40.1.1 - Requirements for Handling Written Inquiries

(Rev. 1, 10-01-03)

A2-2959.A, B2-5105.A.1

- Date Stamping: Contractors must stamp all written inquiries with the date of receipt in the corporate mailroom and control them until final answers are sent.
- Timeliness: Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

If contractors are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45 day period starts on the same day for both responses).

Contractors must ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is the most efficient for the conditions. If contractors respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor will have the flexibility to respond to provider written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: provider's name and address, telephone number, provider number, date of contact, internal inquiry control number, subject, summary of discussion, status action required (if any) and the name of the customer service representative who handled the inquiry. Upon request, send the provider a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. Use the correspondence, which includes the requestor's telephone number or use a requestor's telephone number from internal records if more appropriate for telephone responses. If the requestor cannot be reached by phone, contractors do not leave a message for the provider to return the call. A written response should be developed within 45 calendar days from the incoming inquiry if the matter cannot be resolved by phone.

- Typewritten Responses: All responses must be typewritten using a font size of 12 and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.
- Contact Information: Include a contact's name and telephone number in the response.
- Appeal Requests: Forward all valid appeals requests to the appeals unit for handling.
- CMS Alpha Representation: Include the official CMS alpha representation on all responses.
- Reproduction: Keep responses in a format from which reproduction is possible.

40.1.2 - Requirements for Responding to Written Inquiries

(Rev. 1, 10-01-03)

A2-2959.A.2, B2-5105.A.2, B2-5105.A.3

Contractors must establish and implement a written plan to strengthen the quality of written responses. The plan should include an internal review process and activities to ensure that the quality of communications is continuously improving. These responses should be reviewed and appraised based on the following requirements for written inquiries:

- **Accuracy -** Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the writer's understanding of the issues that prompted the inquiry.
- **Responsiveness** - The response addresses the writer's major concerns and states an appropriate action to be taken.
- **Clarity** - Letters have good grammatical construction, sentences are of varying lengths (as a general rule, keep the average length of sentences to no more than

12-15 words), and paragraphs generally contain no more than five sentences. All written inquiries are to be processed using a font size of 12 points and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.

- **Timeliness** - Substantive action is taken and an interim or a final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for the delay. All responses, including computer-generated letters and form letters, should be user-friendly and understandable by the reader.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45-day period starts on the same day for both responses).

Contractor personnel must ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined or separate, depending on which procedure is most efficient for a contractor's conditions. If the contractor responds separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor must have the flexibility to respond to provider written inquiries by phone within 45 calendar days. They should develop a report of contact for tracking purposes. It should include:

- Provider's name and address,
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;
- Subject;
- Summary of discussion;
- Status, action required (if any); and
- The name of the customer service representative who handled the inquiry.

Upon request, the contractor sends the provider a copy of the report of contact that results from the telephone response. The contractor retains the report of contact in the same manner and time frame as it does for written responses.

The contractor uses its discretion to identify which written inquiries (e.g., provider correspondence that represent simple questions) it can answer by phone. It uses the correspondence, which includes the requestor's telephone number or it obtains a requestor's telephone number from internal records if it can more appropriately respond to the inquiry by telephone. If the contractor cannot reach the requester by phone, it does

not leave a message for the requester to return the call. It prepares a written response within 45 calendar days from the incoming inquiry if it cannot resolve the matter by phone.

Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Contractors must appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

A - Written Inquiries Files

- Some contractors house files at a remote location during the year due to costs and space constraints. Those contractors must notify CMS within six weeks of the final BPR date of the exact address/location of their off site written inquiries. This information should be sent electronically to the servicing RO Beneficiary Branch Chief. In the event an onsite CPE review is conducted, contractors are required to allow CMS access to all written inquiries stored off site within 1 day of notification to the contractor.
- All written inquiries, whether maintained on site or off site, must be clearly identified and filed in a manner that will allow easy selection for the CPE review. Identification data must be kept that will allow electronic production of a sequential listing of the universe of written inquiries.

Effective FY 2003, all contractors will be expected to:

- Involve clinicians as needed in developing responses to coverage/coding inquiries from providers.
- Use clinicians in scoring the accuracy of responses to coverage/coding inquiries in their quality appraisal program

B - E-mail Inquiries

Any E-mail inquiry received can be responded to by E-mail. Since E-mail represents official correspondence with the public, it is paramount that contractors use sound E-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by E-mail. Contractors must ensure that all E-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.).

40.2 - Telephone Inquiries

(Rev. 1, 10-01-03)

A2-2959.C, B2-5105.C

The guidelines established below apply to all calls to telephone numbers the contractor established as general provider inquiry numbers. The standards do not apply to those inquiries handled by other units within the contractor (i.e. appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) must be separate from beneficiary inquiry numbers. Providers should not use numbers established for inquiries from beneficiaries. (For MSP Situations,

see Medicare Secondary Payer (MSP) Manual, Chapter 4, §§10, 80, 110; and Chapter 5, §10.)

A - Availability of Telephone Service

Contractors must:

8. Hours of Operation: Make live telephone service available to callers continuously during normal business hours--including break and lunch periods. The minimal "normal business hours" for live telephone services are 9:00 a.m. until 3:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a request for a waiver related to standard hours of operation.
9. IVR Hours of Operation: To the extent possible, the IVR shall be available to providers from 6:00 a.m. through 10:00 p.m. in their local prevailing time, Monday through Friday, and from 6:00 a.m. until 6:00 p.m. on weekends. Allowances may be made for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. Contractors should identify what services can be provided to providers during the processing system unavailable time.

   NOTE: Interactive Voice Response Units (IVR) should be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVRs
10. Delay Message: Although the provider should have the ability to speak with a CSR during operating hours, if callers encounter a temporary delay before a CSR is available, a recorded message will inform them of the delay. The message will also request that the provider have certain information readily available before speaking with the agent. During peak volume periods, the message shall indicate the preferred time to call.
11. At the beginning of each fiscal year, contractors will send CMS their list of call center holiday closures for the entire fiscal year. This information should be sent to: ServiceReports@cms.hhs.gov. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work (e.g., provide CSR training.
12. Call Center Staffing: Staffing should be based on the pattern of incoming calls per hour and day of the week ensuring that adequate coverage of incoming calls throughout the workday is maintained in accordance with call center standards. Telephone service must not be interrupted in order to conduct CSR training.
13. CSR Identification to Callers: CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will by optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where

the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. The CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

14. Performance Improvements: As needed, develop a corrective action plan to resolve deficient performance by staff in the call center, and maintain results on file for CMS review.

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of IVR. The contractor should strive to use the IVRs based upon lessons learned and best practices throughout CMS and its partners. All contractors are required to utilize an IVR that meets the following guidelines:

- Busy Signals: Call center customer premise equipment should not be configured/programmed to return "soft busies." Contractor call centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor should optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.
- IVR Content: The IVR should offer at least the following information:
    6. Contractor hours of operations for inbound Medicare provider CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold.
    7. General Medicare program information.
    8. Specific information regarding claims in process and claims completed.
    9. A statement if additional evidence is needed to have a claim processed.
    10. Information about appeal rights and actions required of a provider to exercise these rights.
- IVR Call Flow: Call centers must submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are performing through the IVR. Contractors must also indicate how they are authenticating the call when claim specific information is involved. The contractors can deliver this document in Visio, Paintbrush, Word, or PowerPoint. A copy should be sent to both the contractor's regional office (RO) and the central office (CO) at ServiceReports@cms.hhs.gov. If the contractor changes the IVR script or call flow, they must submit a revised document to these parties within 2 WEEKS OF IMPLEMENTING THE CHANGES.

- IVR Operating Guide: The contractors must have a readily understood IVR operating guide to distribute to providers upon request.

B - Toll-Free Telephone Service Costs

The CMS will use the General Service Administration's Federal Telephone Service (FTS) 2001 contract for all inbound toll-free service. Any new toll-free numbers and the associated network circuits used to carry these calls will be acquired via the FTS 2001 network. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS and should not be considered by contractors in their budget requests. However, Medicare contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors must maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and provide this information upon request by RO or CO.

Contractors must print on their notices and Web sites any toll-free Medicare provider customer service number that the CMS provides and pays for. Contractors display this toll-free number prominently so the reader will know whom to contact regarding the notice.

C - Customer Service Representative (CSR) Standard Desktop

The CMS is transitioning to the Medicare Customer Service Center Next Generation Desktop (MCSC NGD) FOR Medicare contractors. Listed below are the minimum personal computer (PC) requirements for the MCSC NGD for CSRs. Contractors are reminded that they are required to capitalize and depreciate equipment valued at over $500.

Minimum Requirements for an NGD Personal Computer

Processor:	Pentium II 233MHz or comparable AMD or Cyrix
Disk Space:	10MB available
Memory:	64MB (more recommended for running multiple applications simultaneously with the NGD)
Operating System:	One of the following 4 options: • Windows 98 SE • Windows ME • Windows NT Workstation 4.0 with Service Pak 6a • Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	15" (17" or larger is preferable)
Pointing Device:	Mouse
Network Interface:	Network Interface Card compatible with the call center LAN which will ultimately allow workstation access to AGNS

Organizations that will be procuring new PCs because they currently do not have PCs or because they need to upgrade for reasons other than the new NGD application, may want to procure more current PC technology. While the minimum PC requirements should be used to evaluate if existing desktop systems are adequate, the following suggested configuration provides guidance when new hardware is purchased:

Guidance for New PCs If and Only If Existing PCs Do Not Meet Minimum Requirements

Processor:	1.0 GHz Processor (Pentium, Celeron, or AMD)
Disk Space:	20 GB Hard drive
Memory:	256 MB (minimum)
Operating System:	Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	17" or larger
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN which will ultimately allow workstation access to AGNS

This hardware should provide good performance running the combination of applications expected of typical NGD users. These applications include, but are not limited to:

- Next Generation Desktop (using Internet Explorer)
- Microsoft Word
- Microsoft Outlook (or other e-mail/calendar package)
- Adobe Acrobat Reader, Folio, or other document viewing software

Personal Computer Software:

- Web browser (Internet Explorer 5.5 Service Pack 2)
- Microsoft Word '97 (or higher version) – required only for generation of correspondence.

Contractors will be required to implement the new desktop application as it is rolled out. The CMS will provide additional information on rollout dates and associated activities through normal operating channels and contractors will be given a minimum of 90 days advance notice of desktop implementation. Contractors are responsible for providing the necessary support to implement the desktop. These support activities will vary in scope from one contractor to another based on the various technologies and operational practices employed at each site. Examples of support activities may include additional systems testing, connecting to contractor specific applications, pre and post deployment activities, training needs and other issues. Contractors should include implementation and all associated costs for the CSR desktop in the Provider Telephone Inquiries Activity Code 33001.

D - Inquiry Staff Qualifications

Contractors train CSRs to respond to provider questions, whether of a substantive nature, a procedural nature, or both. The CSRs who answer telephone calls must be qualified to answer general questions about initial claims determinations, operation of the Medicare program, and appeal rights and procedures. To ensure that these services are provided, CSRs should have the following qualifications:

- Good keyboard computer skills;
- Good telephone communications skills;
- Sensitivity for special concerns of the Medicare providers;
- Flexibility to handle different situations that may arise;
- Knowledge of Medicare claims processing and review procedures;
- Prior experience in positions where the above skills are used, e.g., claims representative or telephone operator, is desired, but not required;
- Contractors will provide training for all new CSR hires and training updates as necessary for existing personnel. This training should enable the CSRs to answer the full range of customer service inquiries. The training at a minimum should include technical instructions on Medicare eligibility, coverage benefits, claims processing, Medicare systems and administration, customer service skills and telephone techniques, and the use of a computer terminal. Contractors must have a training evaluation process in place to certify that the trainee is ready to independently handle questions;
- During FY 2003, CMS will be developing testing and issuing standardized training processes and materials for provider telephone CSRs. Upon receipt of these materials, contractors are required to implement these standardized CSR training materials, including job aids for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures;
- Send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors should be prepared to send at least one customer service/provider education representative to these training sessions to represent areas of provider education/customer service, payment, claims processing, billing, and medical review. Contractors should expect training sessions to run from 2-4 days. This representative will be responsible for training additional contractor customer service staff. These staff members should also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives; and

Call Center User Group (CCUG) Call: Call centers are required to participate in the monthly CCUG calls. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern time. The CCUG sessions provide a forum for CMS to discuss new and

ongoing projects related to telephone customer service, for contractors to surface issues for CMS resolution, and call centers to share best practices in telephone customer service delivery. The call center manager or a designated representative must participate ate a minimum.

E - Customer Service Assessments and Management System (CSAMS)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display Call Center Telephone Performance data. Contractors use the following guidelines for the appropriate CSAMS reporting:

- Monthly Reports: Each call center site must enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To correct or change data after the10th of the month, users must inform central office via CSAMS at csams@cms.hhs.gov. All specified information must be captured and reported to CMS on a monthly basis via the CSAMS. This information may be captured manually, if necessary, to calculate each required field.
- Call Center Definition for CSAMS: All contractors must ensure that monthly CSAMS data are being reported by individual call center and that the data are not being consolidated. The CMS wants telephone data grouped at the lowest level possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, MCSC, or some breakout/consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, State, etc.
- The CSRs Sign-in Policy: Establish and follow a standard CSR sign-in policy in order for CMS to ensure data collected for telephone performance measurement is consistent from contractor to contractor. This policy will include the following:

    5. The CSRs available to answer telephone inquiries will sign-in to the telephone system to begin data collection.
    6. The CSRs should sign-off the telephone system for breaks, lunches, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR work-state or category that accumulates this non-telephone inquiry performance data so that it can be separated and not be utilized in lieu of CSRs signing off the system.)
    7. The CSRs should sign-off the telephone system at the end of their workday.
    8. Call Handling Reporting Requirements for CSAMS:

- Contractors must track and report “Total Sign-in Time” (TSIT). Total sign-in time is the amount of time that CSRs were available to answer telephone inquiries. This time includes that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.

- Contractors must track and report "Available Time." Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the After Call Work [ACW]state).
- Contractors must track and report "Number of Workdays." Number of workdays is the number of calendar days for the month that the call center is open and processing telephone inquiries. For reporting purposes, a call center is considered open for the entire day even though the call center may have been closed or not able to process telephone inquiries for a portion of the day.
- Contractors must track "Call Acknowledgement Rate." Call acknowledgement rate is the time it takes a system to acknowledge a call before an agent, IVR, or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported but must be substantiated when requested.
- Contractors must track and report "Service Level Indicator." For callers choosing to talk with a CSR, calls shall be answered within a specified time of their delivery to the queuing system. This rate should be reported to CMS monthly.
- Contractors must track and report "Initial Call Resolution." A call is considered resolved during the initial contact if it does not require a return call by the CSR.
- Contractors must track and report "Number of Attempts." Report the monthly total FTS toll-free calls offered to the provider call center during the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-CMS calls. This should be taken from reports produced by FTS Toll-free service provider. The current provider is WorldCom and the reports are available at their Web site, http://customercenter.worldcom.com.
- Contractors must track and report "Call Abandonment Rate." Call abandonment rate is the percentage of provider calls that abandon their call from the ACD queue up to and including 60 seconds.
- Contractors must track and report "Average Speed of Answer." Average speed of answer is the amount of time that all calls waited in queue before being connected to a CSR. This time begins when the caller enters the queue (it includes ringing, delay recorder(s), and music.
- Contractors must track and report "Average Talk Time." Average talk time is any time the caller is placed on hold by the CSR.
- Contractors must track and report "Productivity." Productivity is the average number of calls handled per CSR.
- Contractors must track and report "After Call Work." After call work (ACW) is the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

- Contractors must track and report "Call back Report." Call back is the number of calls not resolved at first contact. Those calls should be reported as follows:
- Callbacks required: This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.
- Callbacks closed within 5 workdays: This number is based on calls received for the calendar month and represents the number of inquiries closed within 5 workdays even if a callback is closed within the first 5 workdays of the following month. For call centers that have transitioned to the Next generation desktop (NGD), the collection of this data point will be automated and will be based on 7 calendar days rather than 5 workdays.
- IVR Handle Rate: Contractors should report the IVR handle rate. This is the number of calls delivered to the IVR where providers received the information they required from the automated system.

F - Quality Call Monitoring Process

Contractors must monitor, measure, and report the quality of service continuously by employing CMS' quality call monitoring (QCM) process. Copies of the official scorecard and chart may be obtained at the telephone customer service Web site at http://www.cms.hhs.gov/callcenters/qcm.asp. Contractors use only the official version of the scorecard posted at the Web site.

1. QCM Sampling Method: Monitor CSRs throughout the month using a sampling routine. The sampling routine must ensure that CSRs are monitored at the beginning, middle, and end of the month (ensuring that assessments are distributed throughout the week and during morning and afternoon hours). Monitor the calls in any combination of the following ways: live remote, live side-by-side (shadow), or taped. For taped calls CMS requires contractors to maintain such tapes for an on-going 90-days period during the year. All tapes must be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Where possible, rotate auditors regularly among the CSRs.
2. Calibration Calls: Participate in national and regional calibration sessions in organized by CMS. Calibration is a process to help maintain fairness, objectivity, and consistency in scoring calls by staff within one or more call centers or throughout CMS. Instructions on how to conduct calibration are posted at the telephone customer service website. National sessions are held on the first Wednesday of February, May, August, and November at 1:30 Eastern time. Contractor call centers with more than one quality assurance analyst should conduct regular calibration sessions.
3. Scorecard: Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.

4. Feedback to CSR: Complete the scorecard in its entirety and give feedback to the CSR in a timely fashion, coaching and assisting the CSR to improve in areas detected during monitoring. Feedback on monitored calls shall be given to within two business days for live monitored calls and within seven business days for recorded calls.

G - QCM Reporting Requirements for CSAMS

Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls without assistance of a "mentor." Scores for these trainees may be excluded from CSAMS reporting for a period up to one month following the end of formal classroom training.

- QCM-Number of CSRs available for monitoring: Contractors must track and report the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time. This number is obtained from the QCM Database.
- QCM-Number of completed scorecards: Contractors must track and report the number of completed scorecards for the month. This number is obtained from the QCM Database.
- QCM-Customer Skills Assessment: Contractors must track and report the percent of calls monitored that scored greater than or equal to Meets expectations. This number is obtained from the QCM Database.
- QCM-Knowledge Skills Assessment: Contractors must track and report the percent of calls monitored that scored greater than or equal to Meets Expectations. This number is obtained form the QCM Database.
- QCM-Privacy Act: Contractors must track and report the percentage of calls that scored as pass. This number is obtained from the QCM Database.

H - Calls Regarding Claims

When a telephone representative receives an inquiry from a provider about a claim, first, verify the provider's name, identification number. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the caller.

I - Calls Regarding Fraud and Abuse

If a caller indicates an item or service was not received, or that a beneficiary or provider is involved in some potential fraudulent activity, screen the complaint for billing errors or abuse before sending it to the Benefit Integrity Unit. After screening the claim, if the CSR suspects abuse, the Medical Review Unit would handle the complaint. If the CSR suspects fraud, the complaint is forwarded to the Benefit Integrity Unit and the CSR informs the caller that the Benefit Integrity Unit will contact him/her about the complaint. The CSR asks the caller to provide the Benefit Integrity Unit with any documentation he or she may have that substantiates the allegation. The CSR assures caller that the matter will be investigated.

J - Equipment Requirements

To ensure that inquiries receive accurate and timely handling, contractors provide the following equipment:

- Online access to a computer terminal for each telephone representative responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;
- An outgoing line for callbacks; and
- A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

Any contractor call center upgrades or initiatives for purchases or developmental costs of hardware, software, or other telecommunications technology that equal or exceed $10,000 must first be approved by CMS. Contractors shall submit all such requests to the servicing RO for review.

The RO shall forward all recommendations for approval to CO for a final decision

K - Publicizing Provider Toll-Free Lines

Effective with the publication of these instructions, contractors will not be responsible for publishing their provider inbound 800 numbers in local telephone directories. The CMS will publish provider inbound 800 numbers in the appropriate directories. No other listings are to be published by the contractor.

However, contractors must publicize the toll-free service to the providers they serve in other normal business ways. An announcement about the availability of the service should be prominently displayed and maintained on contractor's Medicare Web site. Toll-free numbers should also be displayed on all provider education materials. Finally, the toll-free numbers should be publicized at all scheduled provider conferences, meetings and workshops.

40.3 - Processes for Line Changes, Troubleshooting, and Disaster Recovery

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A - Ordering More Lines, Changing Configurations, or Disconnecting Lines

The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or Tis, office moves, routing changes), must be processed through SAIC, the Provider Telecommunications Technical Support Contractor.

The CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of CSAMS data and traffic reports.

In requesting changes to the phone environment, the contractor should follow the process outlined below:

Contractors will provide an analysis of their current telephone environment including a detailed traffic report specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information should be gathered at the contractor site through the contractor's switch reporting as well as through WorldCom Customer Center (previously Interact).

- Based on technical merit and availability of funds, CO will review the recommendation and make a determination.

In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

B - Troubleshooting

To ensure that provider toll-free service is available and clear, CMM established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard, incident response and resolution system for Medicare contractors who are troubleshooting problems and processing required changes for the toll-free provider lines.

The CMM has assembled a multi-functional team, consisting of both MCI telecommunications support and CMM Technical Support Contractor (TSC) personnel; to quickly and effectively resolve reported problems. To report and monitor a problem, contractors follow these steps.

Step 1

Isolate the problem and determine whether it is caused by internal customer premise equipment or the toll-free network service:

Internal Problem - The contractor's local telecommunications personnel should resolve, but report per steps below.

Toll-Free Network Service Problem - Contractor reports the problem to MCI by calling 1-888-387-7821.

Step 2

Involve CMM's Technical Support Contractor (TSC), if needed, to answer technical questions or to facilitate discussions with the GSA FTS provider service.

Step 3

File an incident report with the TSC for major interruptions of service. The TSC will notify CMM staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service.

Step 4

Utilize WorldCom Customer Service to review documentation, track trouble tickets status, or close a trouble ticket online.

Step 5

File a monthly report with CMM about interruption of service - including both those of MCI and in-house origins and send a copy to the contractor's CMS Regional Office.

C - Disaster Recovery

When a call center is faced with a situation that results in a major disruption of service, the call center must take the necessary action to ensure that callers are made aware of the situation.

This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center must contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Once the problem is resolved, the call center must also contact the BNS to de-activate the FTS 2001 network disaster messages.

For provider call centers, contractors contact the BNS should only for the disaster situations. It will manage only these types of requests. The CMS designed the single point of contact to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS contacts and updates the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers should follow their normal procedures.